		FOR OHF USE					

LL1

2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0032904

Facility Name: Manorcare at Libertyville

Address: 1500 S. Milwaukee Ave. (Number) Libertyville (City) 60048 (Zip Code)

County: Lake

Telephone Number: (708) 816-3200 **Fax #** (708) 816-8981

IDPA ID Number: 520886946009

Date of Initial License for Current Owners: 02/02/88

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Craig Dekany **Telephone Number:** (419) 252-5740

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 06/01/03 to 05/31/04 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name) Barry Lazarus
(Title) Vice-President Reimbursement

Paid Preparer
(Signed) (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Manorcare at Libertyville # 0032904 Report Period Beginning: 06/01/03 Ending: 05/31/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	150	Skilled (SNF)	150	54,900	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	150	TOTALS	150	54,900	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	22,268	3,951	12,246	38,465	8
9	SNF/PED					9
10	ICF	4,066	2,926	848	7,840	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	26,334	6,877	13,094	46,305	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.34%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 02/23/88

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 02/23/88 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 150 and days of care provided 10,013

Medicare Intermediary CareFirst of Maryland, Inc.

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [ ] NO [X]

Tax Year: 12/31/04 Fiscal Year: 05/31/04

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Manorcare at Libertyville # 0032904 Report Period Beginning: 06/01/03 Ending: 05/31/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	313,888	17,124	1,863	332,875	2,751	335,626		335,626			1
2	Food Purchase		210,678		210,678		210,678	(2,466)	208,212			2
3	Housekeeping	133,777	19,941	390	154,108		154,108		154,108			3
4	Laundry	34,291	30,327	401	65,019		65,019		65,019			4
5	Heat and Other Utilities			149,104	149,104	10,026	159,130	(353)	158,777			5
6	Maintenance	56,128	28,756	87,977	172,861		172,861		172,861			6
7	Other (specify):* Med Waste			2,185	2,185		2,185		2,185			7
8	**TOTAL General Services**	538,084	306,826	241,920	1,086,830	12,777	1,099,607	(2,819)	1,096,788			8
	B. Health Care and Programs											
9	Medical Director			23,400	23,400		23,400		23,400			9
10	Nursing and Medical Records	2,758,019	191,797	184,715	3,134,531	59,142	3,193,673	(2,051)	3,191,622			10
10a	Therapy	459,717	8,434	42,510	510,661		510,661		510,661			10a
11	Activities	102,281	4,291	1,916	108,488		108,488		108,488			11
12	Social Services	100,744		428	101,172		101,172		101,172			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	3,420,761	204,522	252,969	3,878,252	59,142	3,937,394	(2,051)	3,935,343			16
	C. General Administration											
17	Administrative	63,496		719,809	783,305	(412,774)	370,531		370,531			17
18	Directors Fees											18
19	Professional Services			40,251	40,251	(635)	39,616	(39,616)				19
20	Dues, Fees, Subscriptions & Promotions			96,366	96,366		96,366	(40,481)	55,885			20
21	Clerical & General Office Expenses	312,757	49,346	215,714	577,817	635	578,452	(176,434)	402,018			21
22	Employee Benefits & Payroll Taxes			848,205	848,205	66,712	914,917		914,917			22
23	Inservice Training & Education			5,582	5,582		5,582		5,582			23
24	Travel and Seminar			11,043	11,043		11,043		11,043			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			169,832	169,832		169,832		169,832			26
27	Other (specify):*											27
28	**TOTAL General Administration**	376,253	49,346	2,106,802	2,532,401	(346,062)	2,186,339	(256,531)	1,929,808			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,335,098	560,694	2,601,691	7,497,483	(274,143)	7,223,340	(261,401)	6,961,939			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Manorcare at Libertyville #0032904 **Report Period Beginning:** 06/01/03 **Ending:** 05/31/04

V. COST CENTER EXPENSES (continued)

		Cost Per General Ledger				Reclass-	Reclassified	Adjust-	Adjusted	FOR OHF USE ONLY		
	Capital Expense	Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total			
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			378,593	378,593	36,151	414,744		414,744			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			40,885	40,885	237,992	278,877	(15)	278,862			32
33	Real Estate Taxes			136,994	136,994		136,994	(9,311)	127,683			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			91,212	91,212		91,212		91,212			35
36	Other (specify):*											36
37	**TOTAL Ownership**			647,684	647,684	274,143	921,827	(9,326)	912,501			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		307,708	18,677	326,385		326,385		326,385			39
40	Barber and Beauty Shops			26,031	26,031		26,031		26,031			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			82,350	82,350		82,350		82,350			42
43	Other (specify):*		61,234		61,234		61,234		61,234			43
44	**TOTAL Special Cost Centers**		368,942	127,058	496,000		496,000		496,000			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,335,098	929,636	3,376,433	8,641,167		8,641,167	(270,727)	8,370,440			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Manorcare at Libertyville # 0032904 Report Period Beginning: 06/01/03 Ending: 05/31/04

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(774)	2		4
5	Telephone, TV & Radio in Resident Rooms	(353)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(234)	21		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(4,081)	21		13
14	Non-Care Related Interest	(15)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(86)	21		16
17	Non-Care Related Fees	(3)	21		17
18	Fines and Penalties	(6,000)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(39,616)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(165,449)	21		24
25	Fund Raising, Advertising and Promotional	(38,366)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(9,311)	33		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(6,439)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (270,727)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (270,727)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Manorcare at Libertyville

ID# 0032904

Report Period Beginning: 06/01/03

Ending: 05/31/04

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Vending Revenue	$ (1,692)	2	1
2	Ambulance Expense	(2,051)	10	2
3	Assoc. Dues	(2,115)	20	3
4	Cust. Reimburse	(581)	21	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(6,439)		49

STATE OF ILLINOIS — Summary A

Facility Name & ID Number Manorcare at Libertyville # 0032904 **Report Period Beginning:** 06/01/03 **Ending:** 05/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,466)	0	0	0	0	0	0	0	0	0	0	(2,466)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(353)	0	0	0	0	0	0	0	0	0	0	(353)	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(2,819)	0	0	0	0	0	0	0	0	0	0	(2,819)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(2,051)	0	0	0	0	0	0	0	0	0	0	(2,051)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(2,051)	0	0	0	0	0	0	0	0	0	0	(2,051)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(39,616)	0	0	0	0	0	0	0	0	0	0	(39,616)	19
20	Fees, Subscriptions & Promotions	(40,481)	0	0	0	0	0	0	0	0	0	0	(40,481)	20
21	Clerical & General Office Expenses	(176,434)	0	0	0	0	0	0	0	0	0	0	(176,434)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(256,531)	0	0	0	0	0	0	0	0	0	0	(256,531)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(261,401)	0	0	0	0	0	0	0	0	0	0	(261,401)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Manorcare at Libertyville # 0032904 **Report Period Beginning:** 06/01/03 **Ending:** 05/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(15)	0	0	0	0	0	0	0	0	0	0	(15)	32
33	Real Estate Taxes	(9,311)	0	0	0	0	0	0	0	0	0	0	(9,311)	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(9,326)	0	0	0	0	0	0	0	0	0	0	(9,326)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(270,727)	0	0	0	0	0	0	0	0	0	0	(270,727)	45

Facility Name & ID Number Manorcare at Libertyville # 0032904 Report Period Beginning: 06/01/03 Ending: 05/31/04

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Manor Care, Inc.	100	Health Care & Retirement Corporation of America (See H.O Cost Report)	Toledo,OH			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	See	Home Office Allocation	$ 719,809	HCR Manor Care,Inc.	100.00%	$ 719,809	$	1
2	V	Page							2
3	V	8							3
4	V								4
5	V								5
6	V	10a	Therapy Management	20,847	Heartland Management Services	100.00%	20,847		6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 740,656			$ 740,656	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Manorcare at Libertyville # 0032904 Report Period Beginning: 06/01/03 Ending: 05/31/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Manorcare at Libertyville # 0032904 Report Period Beginning: 06/01/03 Ending: 05/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: HCR Manor Care, Inc.
Street Address: 333 North Summit St.
City / State / Zip Code: Toledo, OH. 43604
Phone Number: (419)252-5500
Fax Number: (419)254-5494

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary - Direct	Accumulated Cost	2,402,993,349	369 Nurs. Fac.	$ 0	$	8,370,645	$ 0	1
2	1	Dietary - Pooled	Accumulated Cost	2,860,540,914	369 Nurs. Fac.	940,169	509,589	8,370,645	2,751	2
3	5	Utilities - Direct	Accumulated Cost	2,402,993,349	369 Nurs. Fac.	288,728		8,370,645	1,006	3
4	5	Utilities - Pooled	Accumulated Cost	2,860,540,914	369 Nurs. Fac.	3,082,391		8,370,645	9,020	4
5	10	Nursing - Direct	Accumulated Cost	2,402,993,349	369 Nurs. Fac.	11,758,547	7,451,541	8,370,645	40,960	5
6	10	Nursing - Pooled	Accumulated Cost	2,860,540,914	369 Nurs. Fac.	6,213,377	3,630,890	8,370,645	18,182	6
7	17	General & Admin - Direct	Accumulated Cost	2,402,993,349	369 Nurs. Fac.	17,137,345	15,146,077	8,370,645	59,697	7
8	17	General & Admin - Pooled	Accumulated Cost	2,860,540,914	369 Nurs. Fac.	84,524,208	36,356,102	8,370,645	247,339	8
9	22	Employee Benefits - Direct	Accumulated Cost	2,402,993,349	369 Nurs. Fac.	4,283,731		8,370,645	14,922	9
10	22	Employee Benefits - Pooled	Accumulated Cost	2,860,540,914	369 Nurs. Fac.	17,698,741		8,370,645	51,791	10
11	30	Depreciation - Direct	Accumulated Cost	2,402,993,349	369 Nurs. Fac.			8,370,645	(0)	11
12	30	Depreciation - Pooled	Accumulated Cost	2,860,540,914	369 Nurs. Fac.	12,354,014		8,370,645	36,151	12
13										13
14	32	Interest				11,412,188			237,992	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 169,693,439	$ 63,094,199		$ 719,809	25

Facility Name & ID Number Manorcare at Libertyville # 0032904 Report Period Beginning: 06/01/03 Ending: 05/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Conv. Sub. Debentures		X	Facility			$ 3,244,133	$ 3,244,133			$ 237,992	1
2	National City Bank, Trustee						650,995	650,995			40,870	2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 3,895,128	$ 3,895,128			$ 278,862	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 3,895,128	$ 3,895,128			$ 278,862	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** N/A **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Manorcare at Libertyville # 0032904 Report Period Beginning: 06/01/03 Ending: 05/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	142,555	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	133,244	2
3. Under or (over) accrual (line 2 minus line 1).	$	(9,311)	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)	$	133,244	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	3,750	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	127,683	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1999	132,504	8
	2000	136,241	9
	2001	69,625	10
	2002	142,408	11
	2003	133,244	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Manorcare at Libertyville COUNTY Lake

FACILITY IDPH LICENSE NUMBER 0032904

CONTACT PERSON REGARDING THIS REPORT Craig Dekany

TELEPHONE (419) 252-5740 FAX #: (419) 254-5495

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	11-28-401-003	See Attached	$ 62,404.28	$ 62,404.28
2.	11-28-401-003	See Attached	$ 62,404.27	$ 62,404.27
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 124,808.55	$ 124,808.55

B. **Real Estate Tax Cost Allocation**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? ____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 200 tax bill which is normally paid during 2004

Facility Name & ID Number Manorcare at Libertyville # 0032904 Report Period Beginning: 06/01/03 Ending: 05/31/04

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 36,902 B. General Construction Type: Exterior Masonary Frame Steel, Fire Resistant Number of Stories 3

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1988	$ 476,076	1
2			2000	9,118	2
3	TOTALS			$ 485,194	3

Facility Name & ID Number Manorcare at Libertyville # 0032904 Report Period Beginning: 06/01/03 Ending: 05/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	150			1988	$ 4,592,131	$ 114,803		$ 114,803	$	$ 1,811,299	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Building Improvements (Current Year Depreciation)					163,851		163,851		1,275,122	9
10				1988	68,073						10
11				1989	52,434						11
12				1990	30,247						12
13				1991	67,316						13
14				1992	175,480						14
15	RETIREMENTS			1992	(10,437)						15
16				1993	55,746						16
17				1994	135,262						17
18				1995	66,532						18
19	FLOOR VINYL/TILE & INSTALLATION			1996	31,353						19
20	CAPITALIZED LABOR-NURSES STATION RENOV			1996	7,272						20
21	C/R 5/31/99 AUDIT ADJ. - CAPITAL LABOR			1996	(7,272)						21
22	WALLVINYL/SIGNS			1996	5,576						22
23	CARPET			1996	4,210						23
24	INNER CAMERA MONITOR			1996	4,177						24
25	SIDING			1996	2,205						25
26	REPAIR LOOSE BRICKS			1996	2,183						26
27	NURSES STATION RENOVATION			1996	11,271						27
28	DOOR RELEASE			1996	2,071						28
29	REMODELING			1996	1,129						29
30	WATER HEATER			1996	5,313						30
31	CARPET/INSTALLATION			1996	2,991						31
32	FLOORING/TILE			1996	23,312						32
33	DOOR FRAME/GUARDS			1996	4,941						33
34	KITCHEN CELING TILE			1996	3,638						34
35	WALLCOVERINGS			1996	4,964						35
36	ELECTRICAL/LIGHTING			1996	3,055						36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number Manorcare at Libertyville # 0032904 Report Period Beginning: 06/01/03 Ending: 05/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	CABINETRY	1996	$ 5,880	$		$	$	$	37
38	REBUILD NURSES STATION	1996	8,500						38
39	INSTALL SWING DOORS	1996	8,826						39
40	INSTALL BALLUSTER POSTS	1996	2,500						40
41	FLOOR COVING	1996	7,791						41
42	BRICK PIER/CONCRETE SIDEWALK	1996	3,880						42
43	INSTALL BOULDER EDGE	1996	4,830						43
44	NURSES STATION RENOVATIONS	1996	1,506						44
45	WALLVINYL	1997	18,304						45
46	CARPETING	1997	1,624						46
47	DECORATING	1997	45,045						47
48	BRICK PIER	1997	1,500						48
49	EXTERIOR ENTRY DOORS	1997	3,317						49
50	PAINTING	1997	7,449						50
51	INSTALL CONDENSING COILS	1997	2,583						51
52	LANDSCAPE	1997	59,118						52
53	CURBING/ASPHALT	1997	30,000						53
54	ROOFING	1997	1,536						54
55	CORPORATE OVERHEAD-PARKING LOT	1997	10,516						55
56	C/R 5/31/99 AUDIT ADJ. - FAC PLAN ALLOC	1997	(10,516)						56
57	PARKING LOT WORK	1997	25,000						57
58	FACILITY PLAN ALLOC	1997	5,964						58
59	C/R 5/31/99 AUDIT ADJ. - FAC PLAN ALLOC	1997	(3,206)						59
60	C/R 5/31/99 AUDIT ADJ. - FAC PLAN ALLOC	1997	(2,759)						60
61	ELEVATOR REPAIRS	1997	5,018						61
62	SECURITY SYSTEM	1997	16,954						62
63	NEW EXHAUSTERS	1997	6,310						63
64	BUILD & INSTALL CABINETS	1997	6,512						64
65	CARPET	1997	5,148						65
66	LANDSCAPE	1997	25,279						66
67	CURB/ASPHALT	1997	45,210						67
68	INSTALL CEDAR FENCE	1997	2,750						68
69	DRUM SLUDGE REMOVAL	1997	2,563						69
70	TOTAL (lines 4 thru 69)		$ 5,700,105	$ 278,654		$ 278,654	$	$ 3,086,421	70

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Manorcare at Libertyville # 0032904 Report Period Beginning: 06/01/03 Ending: 05/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 5,700,105	$ 278,654		$ 278,654	$	$ 3,086,421	1
2	INSTALL OIL TANK	1997	11,779						2
3	FLOORING/CEILING	1998	1,115						3
4	CARPETING	1998	2,574						4
5	ARCHITECT/PROFESSIONAL FEES-ADMIN OFFICE	1998	3,685						5
6	PAINTING/WALLPAPER	1998	10,125						6
7	RENOVATE ADMIN OFFICE	1998	2,533						7
8	ENERGY AUDITS	1998	1,875						8
9	GENERAL CONTRACTOR FEES-ADMIN OFFICE	1998	4,165						9
10	CORPORATE OVERHEAD-ADMIN OFFICE	1998	1,651						10
11	C/R 5/31/99 AUDIT ADJ - MONTHLY CAP BUDGET	1998	(1,651)						11
12	INSTALL FENCE/GAZEBO	1998	2,153						12
13	PAINTING/WALLCOVERING	1998	5,821						13
14	PLUMBING	1998	5,250						14
15	ELECTRICAL	1998	8,883						15
16	DEVELOPERS-ADMIN OFFICE	1998	5,555						16
17	SIGN	1998	11,862						17
18	ROOFING	1998	5,520						18
19	MASONARY	1998	4,766						19
20	CARPENTRY	1998	3,137						20
21	PAINTING/WALLCOVERING	1999	6,873						21
22	ELECTRICAL	1999	6,590						22
23	FLOORING/CEILING	1999	8,230						23
24	CARPENTRY	1999	12,373						24
25	MILLWORK	1999	540						25
26	FINISH STUDS	1999	20,000						26
27	PAVING	1999	35,325						27
28	CARPET FOR BUILDING	1999	11,611						28
29	WINDOW TREATMENTS	1999	10,291						29
30	KNOBLOCKS, CYPHER	1999	1,448						30
31	CARPET, CREDIT	1999	(13,990)						31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,890,194	$ 278,654		$ 278,654	$	$ 3,086,421	34

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Manorcare at Libertyville # 0032904 Report Period Beginning: 06/01/03 Ending: 05/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 5,890,194	$ 278,654		$ 278,654	$	$ 3,086,421	1
2	SALES TAX, CARPET	1999	71						2
3	CARPET	1999	148						3
4	DOOR FRAME FOR BOILER ROOM	1999	2,550						4
5	ELECTRICAL CIRCUITS, HEATER	1999	5,937						5
6	PTAC UNITS	1999	2,920						6
7	DOOR, HARDWARE, & STAIN	2000	1,025						7
8	ADDTL COST GARAGE	2000	1,671						8
9	SECURE CARE SYS 2ND FL STAIRWELL	2000	3,147						9
10	DOOR - SOUTH CORRIDOR EXIT	2000	2,440						10
11	PANIC DEVICE - EXTERIOR DOOR	2000	760						11
12	2 A/C UNITS	2000	1,156						12
13	GARAGE	2000	21,256						13
14	LANDSCAPING	2000	2,675						14
15	LANDSCAPING - ARBORIVITAE	2000	3,784						15
16	GARAGE	2000	19,209						16
17	GARAGE	2000	5,556						17
18	BOILER	2001	4,525						18
19	FIRE WALL IN ATTIC	2001	7,422						19
20	A/C UNIT	2001	597						20
21	4 A/C UNITS	2001	2,680						21
22	WORKCOUNTER & CABINETS	2001	2,219						22
23	GATES	2001	4,760						23
24	ELECTRICAL CIRCUITS	2001	1,279						24
25	ARCADIA CORRIDORS & LOUNGE	2001	132,623						25
26	ARCADIA CORRIDORS & LOUNGE	2001	5,666						26
27	ARCADIA CORRIDORS & LOUNGE	2001	124,865						27
28	ARCADIA CORRIDORS & LOUNGE	2001	20,483						28
29	ARCADIA CORRIDORS & LOUNGE	2001	181,656						29
30	CARPENTRY, DOORS, ELECT.	2001	52,344						30
31	VWC, CORNER GUARDS	2001	10,041						31
32	DINING ROOM & BREAKROOM	2003	21,720						32
33	RETROACTIVE ADDITION	2003	(588)						33
34	TOTAL (lines 1 thru 33)		$ 6,536,792	$ 278,654		$ 278,654	$	$ 3,086,421	34

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Manorcare at Libertyville # 0032904 Report Period Beginning: 06/01/03 Ending: 05/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 6,536,792	$ 278,654		$ 278,654	$	$ 3,086,421	1
2	ARCH&ENGINEER COSTS, PLANS REVIEWS	2003	16,667						2
3	GENERAL OVERHEAD & INTEREST	2003	33,439						3
4	CARPETING & PADS, WALLCOVERINGS	2003	74,310						4
5	CARPENTRY & MILLWORK	2003	5,750						5
6	HVAC & ELECTRICIAL WORK	2003	30,572						6
7	HM DOORS & FRAMES	2003	3,662						7
8	WARDROBES	2004	11,000						8
9	FLOORING	2004	761						9
10	GENERAL OVERHEAD & INTEREST	2004	32,935						10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,745,888	$ 278,654		$ 278,654	$	$ 3,086,421	34

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Manorcare at Libertyville # 0032904 Report Period Beginning: 06/01/03 Ending: 05/31/04

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 930,222	$ 99,939	$ 99,939	$		$ 647,633	71
72	Current Year Purchases	237,192						72
73	Fully Depreciated Assets							73
74	Home Office Allocation			36,151	36,151			74
75	TOTALS	$ 1,167,414	$ 99,939	$ 136,090	$ 36,151		$ 647,633	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 8,398,496	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 378,593	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 414,744	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 36,151	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,734,054	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Manorcare at Libertyville # 0032904 Report Period Beginning: 06/01/03 Ending: 05/31/04

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. [ ] YES [X] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	N/A			$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [X] YES [ ] NO
16. Rental Amount for movable equipment: $ 91,212 Description: 02 Concentrators, Wheelchairs, Gerichairs, Elect. Beds, etc.
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	N/A		$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Manorcare at Libertyville # 0032904 Report Period Beginning: 06/01/03 Ending: 05/31/04

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10A	5208 hrs	$ 134,467	313	$ 14,855	$ 1,605	5,521	$ 150,927	1
2	Licensed Speech and Language Development Therapist	10A	1729 hrs	44,648	112	5,284	90	1,841	50,022	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A	10868 hrs	280,602	464	22,007	6,739	11,332	309,348	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39	# of prescrpts				307,708		307,708	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): P/S X-Ray,Lab	10a,39,Col.3			8	19,041		8	19,041	13
14	TOTAL			$ 459,717	897	$ 61,187	$ 316,142	18,702	$ 837,046	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Manorcare at Libertyville # 0032904 Report Period Beginning: 06/01/03 Ending: 05/31/04

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 05/31/04 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 54,902	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (364,446))	754,006		3
4	Supply Inventory (priced at)	11,990		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	4,046		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 824,944	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	485,194		13
14	Buildings, at Historical Cost	6,745,888		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,167,414		16
17	Accumulated Depreciation (book methods)	(3,734,054)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): CIP			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 4,664,442	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,489,386	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 117,814	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	403,397		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	133,244		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Expenses	62,580		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 717,035	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	650,995		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 650,995	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,368,030	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 4,121,356	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,489,386	$	48

***(See instructions.)**

Facility Name & ID Number Manorcare at Libertyville # 0032904 Report Period Beginning: 06/01/03 Ending: 05/31/04

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 4,445,508	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 4,445,508	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(763,251)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (763,251)	17
	B. Transfers (Itemize):		
18	**Change In Interdivision**	439,099	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 439,099	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 4,121,356	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Manorcare at Libertyville # 0032904 Report Period Beginning: 06/01/03 Ending: 05/31/04

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 8,929,162	1
2	Discounts and Allowances for all Levels	(3,337,057)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,592,105	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,919,146	6
7	Oxygen	312	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,919,458	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	1,778	12
13	Barber and Beauty Care	29,976	13
14	Non-Patient Meals	774	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	298,681	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	29,635	19
20	Radiology and X-Ray	3,664	20
21	Other Medical Services		21
22	Laundry	2,076	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 366,584	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	3	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 3	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**Misc Income**	(234)	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ (234)	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,877,916	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,086,830	31
32	Health Care	3,878,252	32
33	General Administration	2,532,401	33
	B. Capital Expense		
34	Ownership	647,684	34
	C. Ancillary Expense		
35	Special Cost Centers	496,000	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,641,167	40
41	**Income before Income Taxes (line 30 minus line 40)****	(763,251)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (763,251)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Manorcare at Libertyville # 0032904 Report Period Beginning: 06/01/03 Ending: 05/31/04

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,726	1,863	$ 63,265	$ 33.96	1
2	Assistant Director of Nursing	3,820	4,123	117,520	28.50	2
3	Registered Nurses	35,149	37,935	1,016,285	26.79	3
4	Licensed Practical Nurses	19,877	21,452	466,174	21.73	4
5	Nurse Aides & Orderlies	90,194	97,343	1,047,990	10.77	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	15,766	17,015	439,389	25.82	7
8	Rehab/Therapy Aides	1,785	1,926	20,328	10.55	8
9	Activity Director	7,644	8,253	102,281	12.39	9
10	Activity Assistants					10
11	Social Service Workers	4,529	4,797	100,744	21.00	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	24,908	27,014	313,888	11.62	15
16	Dishwashers					16
17	Maintenance Workers	4,028	4,365	56,128	12.86	17
18	Housekeepers	12,884	13,918	133,777	9.61	18
19	Laundry	3,765	4,067	34,291	8.43	19
20	Administrator					20
21	Assistant Administrator	1,809	1,809	63,496	35.10	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	16,458	17,878	312,757	17.49	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,518	3,802	46,785	12.31	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	247,860	267,560	$ 4,335,098 *	$ 16.20	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	23,400	5,9,3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 23,400		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	3,851	$ 103,181	5,10,3	50
51	Licensed Practical Nurses	668	14,519	5,10,3	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	4,520	$ 117,700		53

Facility Name & ID Number Manorcare at Libertyville # 0032904 Report Period Beginning: 06/01/03 Ending: 05/31/04

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Greg Seeger	Administrator	0	$ 63,496
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 63,496

B. Administrative - Other

Description	Amount
Home Office Allocation	$ 719,809
TOTAL (agree to Schedule V, line 17, col. 3)	$ 719,809
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Various Vendors	Legal Fees	$ 39,616
Physicians Credit Bureau	Acctg Fees	635
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 40,251

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 126,870
Unemployment Compensation Insurance	48,037
FICA Taxes	313,164
Employee Health Insurance	241,604
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401K / SMSP Match	21,241
Other Employee Benefits	82,432
Employee Uniforms	809
Employee Appreciation	8,248
Tuitition Program	5,800
Home Office Allocation	66,713
TOTAL (agree to Schedule V, line 22, col.8)	$ 914,918

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
N/A		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 5,435
Advertising: Employee Recruitment	40,665
Health Care Worker Background Check	
(Indicate # of checks performed 196.6)	4,916
Dues & Subscriptions	120
Association Dues	6,864
Advertising	38,366
Less: Non-Allowable Assoc. Dues	(2,115)
Less: Public Relations Expense	( )
Non-allowable advertising	(38,366)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 55,885

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Includes travel expense to the Home	11,043
Office in Toledo, OH for regional	
meeting	
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 11,043

**See instructions.

Facility Name & ID Number Manorcare at Libertyville # 0032904 Report Period Beginning: 06/01/03 Ending: 05/31/04

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Manorcare at Libertyville # 0032904 **Report Period Beginning:** 06/01/03 **Ending:** 05/31/04

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IHCA $6,864**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **Yes** If YES, have these costs
been properly adjusted out of the cost report? **Yes $2,115**

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5-10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **69,091** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for
Schedule VII)? YES **X** NO If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department
of Public Aid during this cost report period. $ **82,350**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to
the Department of Public Aid, in addition to the daily rate, been properly classifiec
in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for
the patient census listed on page 2, Section B? **No** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **N/A** Has any meal income been offset against
related costs? **Yes** Indicate the amount. $ **774**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for
residents? **No** If YES, please indicate the amount of income earned from such a
program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other
times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such
transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted ou
out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services
performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.